

S. No. 2  
-11-10-39  
-5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

34520

State File No.

4036

NOV 12 1940

1002

Registration District No.

Primary Registration District No.

Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: K.C. General Hospital No. 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9 days (Specify whether)

In this community 9 yrs.  
years, months or days

3. (a) PRINT FULL NAME ESTELL KELLY

3. (b) If veteran, name war

3. (c) Social Security No. 495-05-3581

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Freda Kelly

6. (c) Age of husband or wife if alive 44 years

7. Birth date of deceased: Nov. 11th 1895  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>44</u>	<u>11</u>	<u>7</u>	<u>hr. min.</u>

9. Birthplace Lewis Station Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Truck driver

11. Industry or business 0

MOTHER FATHER

12. Name Thomas Kelly

13. Birthplace Bonerville Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Thyrthe Fuller

15. Birthplace Idarville Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. C. F. Kelly

(b) Address 2513 Prospect

17. (a) Buried (b) Date thereof 10-21-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Emmerson Cemetery

18. (a) Signature of funeral director Bruce Westaway

(b) Address 1501

19. (a) 10-21-40 (b) M. M. Grove  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")

(d) Street No. 2513 Prospect  
(If rural, give location)

(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 18th  
year 1940 hour 10 minut 05 A. M.

21. I hereby certify that I attended the deceased from Oct. 9th, 1940, to Oct. 18th, 1940; that I last saw him alive on Oct. 18th, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Subdural Hemorrhage  
(If more than one, list in order)

Duration 9 days

Due to 826

Due to \_\_\_\_\_

Other conditions Bronchopneumonia  
(Include pregnancy within 3 months of death)

Terminal Physician

Major findings: Of operations \_\_\_\_\_

Of autopsy See above

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)

Means of injury \_\_\_\_\_

23. Signature Dr. W. C. Gen. Hospital (M. D. or other) \_\_\_\_\_  
Address Med. Dir. W. C. Gen. Hospital Date signed 10-21-40

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No. ....

working under my personal supervision.

Signed G. J. Hoffington

Licensed Embalmer No. 2756

P. O. Address W. E. Moore

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**